contains an outlet stem above the suction stem, is used as a combined source of suction and irrigation.

SUMMARY

Some common obstacles to the performance of proctoscopy have been pointed out, and an instrument described by which these may be overcome.

Medical Center Building.

SQUAMOUS EPITHELIAL BONE CYST OF THE TERMINAL PHALANX*

By WILLIAM W. REICH, M.D.
Berkeley

THIS report is prompted by the recent article by Bissell and Brunschwig.[1] These authors, after presenting a short review of the literature, add two new cases. They also call attention to the probable rôle of trauma in the genesis of the pathologic lesion.

REPORT OF CASE

A German female, aet. forty-three, complained of a tense, painful and tender spot near the tip of her right first finger. She stated that this "sore spot" had been noted for about six months, but that she had absolutely no recollection of having injured the finger in any way. About two weeks previously, a doctor had incised the tip of the finger and she stated that this eased the tension. Her past and family histories presented no relevant data. Examination revealed a very tense, slightly reddened, moderately tender finger. A small zone on the inner border appeared fluctuant. The base of the nail seemed slightly raised. X-ray examination, April 7, 1937, presented the rather striking findings shown in Figure 1. The radiologic diagnosis was chronic osteomyelitis; however, bone cyst, chondroma or other neoplastic process were suggested as possibilities. On April 18, 1937, under local anesthesia, the overlying soft tissues were incised and the underlying bone thoroughly curetted. A fairly well-defined, whitish, membranous shell measuring about 2 by 3 millimeters was scooped out in the process. A small wick was placed in the wound and moist dressings applied. The wound healed rapidly by first intention. No suppuration was encountered either at the time of operation or subsequently. X-rays, taken on May 25, 1937, are shown in Figure 2. It is apparent that very little filling in had taken place, except for the small deposit about the cyst edges. Histological examination of the small shred obtained at operation revealed the wall of a bone cyst lined by typical stratified squamous epithelium. Figures 3 and 4 show, respectively, low- and high-power magnifications.

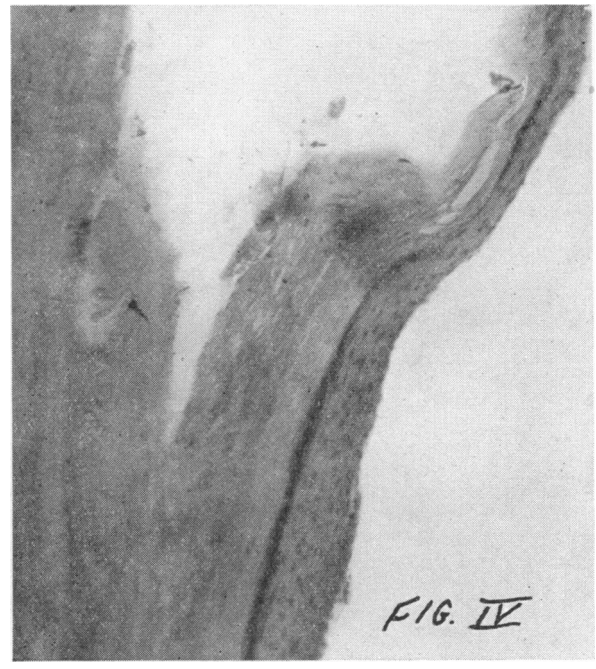

Fig. 4.—Stratified squamous epithelium lining cyst as seen under high powers of the microscope.

In the article quoted above, a discussion of the theories of the origin of these interesting structures is presented. The trauma theory probably explains most cases; however, in some instances, as in the present case, no history of injury could be obtained. It appears that diagnosis must rest upon pathologic examination of curettings, since confusion with other lesions cannot be eliminated by gross examination or radiologic studies.

2236 Durant Avenue.

* I wish to thank Dr. R. D. Joldersma for the opportunity of seeing this patient.

1 Bissell, A. D., and Brunschwig, A.: Squamous Epithelial Bone Cysts of the Terminal Phalanx, J. A. M. A., 108:1702, 1937.

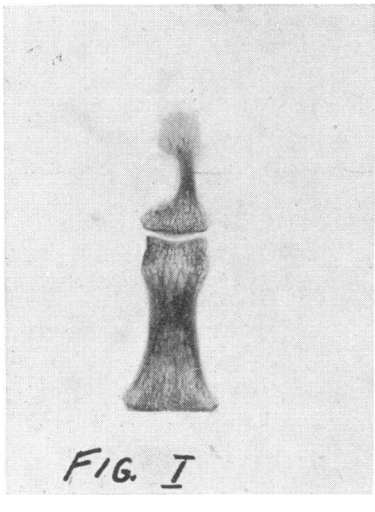

Fig. 1.—Bone cyst; radiogram before operation.

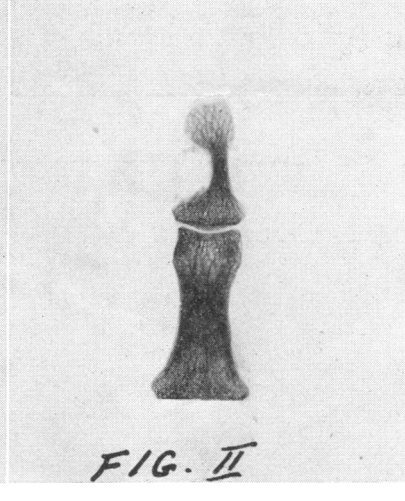

Fig. 2.—Bone cyst after operation; note beginning filling of cyst cavity.

Fig. 3.—Low power appearance of section of cyst wall.